September 15, 2011

Diana Dooley, Secretary, Department of Health and Human Services;
Michael Wilkening, Undersecretary for Program and Fiscal Affairs
California Health and Human Services Agency
1600 Ninth St., Suite 460
Sacramento, CA 95814

Dear Secretary Dooley and Undersecretary Wilkening,

Attached please find an initial set of recommendations from an informal group of California's experts in substance use disorder policy including financial and organizational issues, medical care related to substance use disorder (SUD) treatment, and SUD treatment services and administration. We have formed an Ad Hoc Workgroup regarding D/MC, ADP transition to DHCS and appropriate leadership structure, as well as SUD/MH realignment/integration, including improved integration with the criminal justice system.

We recommend strongly that all current and future functions of ADP be kept intact in a single unit at this point in time, with an ongoing evaluation to assess the continued appropriateness of that arrangement. Whether ADP ultimately becomes a permanent subdivision of DHCS with DMH, moves to a different agency, or stays intact as a Department is a matter to be considered carefully, as you know. However, at this time of great transition and potential change, fragmentation of ADP's functions amongst different State departments could create great confusion amongst its stakeholders, Federal partners and regulatory entities and its highly vulnerable patients and their families/households. A possible exception to this might be practitioner licensing. Facility licensing and accreditation, much of which is controlled at multiple levels including the Federal level, is best kept with the rest of ADP at this time.

As a group we would be delighted to discuss the attached initial recommendations with you and your colleagues. In fact, we respectfully request the opportunity to provide an in-person briefing on this document and other issues involving SUD and related MH services to you and your staff at your earliest convenience. As noted above, we view the conversation as beginning and we appreciate your attention to our comments.

Thank you for the opportunity to submit our recommendations (attached to this e-mail).

Ad Hoc Workgroup Members Endorsing This Initial Document:

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Recommendations Regarding the Reorganization of Functions for the California Department of Alcohol and Drug Programs

The following initial set of recommendations addresses changes to State oversight of alcohol and drug services as proposed in: 1) The transfer of Drug Medi-Cal (D/MC) services administration from the Department of Alcohol and Drug Programs (DADP) to the Department of Health Care Services (DHCS); 2) Realignment of State/County roles related to SUD (Substance Use Disorders; and 3) Possible elimination of DADP as a department and transfer of its functions to another department. We may have more detailed recommendations to add at another time but we think it is critical to send this initial message before structural and leadership decisions are set.

Recommendation Regarding Leadership of Substance Use Disorder (SUD) and Mental Health (MH) Services within DHCS

If DADP and the Department of Mental Health must be folded into another agency, our expert workgroup recommends strongly that DHCS structure an "agency within an agency", mirroring the federal Substance Abuse and Mental Health Services Administration (SAMHSA) within DHCS to deal with substance use disorder and mental health programmatic and financial issues, prevention and treatment, state and Federal functions, and Federal block grant administration. Based on policy research, the leader of this SUD/MH "entity" within DHCS must be of a high rank within the government agency structure to interact effectively with senior state agency directors such as CDCR[1] and also with key Federal officials and counties to ensure credible oversight of the Federal Block Grants, provide effective oversight of the large SUD and MH service systems in California, and promote stronger integration of SUD and MH services with other areas of medical care, including the 1115 waiver initiatives and health reform. The Chief Deputy must also integrate these efforts with and within the criminal justice system at both the State and County levels, which is an absolutely critical issue for substance abuse and mental health patients, even more than for others served by DHCS. The salary for this position/rank must then reflect the ability of this leader to lead integration with other very senior officials and peers and the rank must be adequate to attract and retain candidates with extensive and equal experience and credentials in SUD and MH services, administration and policy matters.

Leadership

We strongly support having a new DHCS Chief Deputy Director (not Deputy Director) for Substance Use Disorder (SUD) and Mental Health Services, on the SAMHSA model, with two Deputy Directors (one for substance abuse and one for mental health), rather than the proposed Deputy Director and two Chiefs. This is important because the State is replacing two Director level, sub-cabinet positions with this recommended Chief Deputy and two Deputies. The new Chief Deputy Director should have substantial and documented experience in policy, administrative and funding leadership, with deep familiarity with state inter/intra-agency partnerships and Federal relationships within both SUD and MH sectors. The two new Deputy Directors should each have deep knowledge of and experience in SUD and MH, respectively,

[1] Note: The head of CDCR is at the Secretary level.

recognition of the inter-relationship of and need to integrate SUD and MH disorder treatments where appropriate and show that she/he is cognizant of and capable of helping to integrate both with the larger healthcare system and with healthcare within and following interventions of the criminal justice system under Realignment. All three positions require exceptional relationship and partnership skills, current and continuing knowledge of research and evidence-based practices and performance management and accountability systems, as well as profound sensitivity for issues of cultural and ethnic identity and diversity, equitable and effective access and fairness.

Recommendation Regarding the Transfer of D/MC into DHCS

Transfer Adequate Personnel from DADP: If D/MC functions are transferred from DADP to DHCS, we strongly recommend that an appropriate and adequate number of experienced staff from DADP are transferred to DHCS to maintain the D/MC services without interruption. Delays and disruptions in services will be avoided by having knowledgeable DADP staff who understand the idiosyncratic billing, data management, and administrative operations that characterize D/MC during this transition.

Distribute Reserve Funds to Counties: Currently DADP retains $7.8 million in unallocated D/MC funds as a reserve to reimburse counties whose D/MC costs exceed their allocation (i.e. a deficiency appropriation). Presumably under Realignment, all of the D/MC funding will go directly to counties from the State's Realignment Revenue Fund. DHCS should develop a plan for how the reserve funds will be allocated if that is the case, with consideration given to the following issues:

- Whether or not the $7.8 million will be adequate to fund future D/MC cost increases. DHCS in collaboration with DADP should map the 5-year history of statewide costs of the D/MC program, broken out by State General Fund and Federal Financial Participation components. In addition, whether or not the size of a county's current D/MC program in relation to its overall Medi-Cal beneficiary population should be considered when allocating these funds.
- Whether or not we should factor in potentially large unknown impacts on D/MC costs, such as Parity and implementation of an essential benefits package under health care reform.

Recommendations Regarding Revisions in the D/MC Benefit

D/MC was never designed as an evidence-based benefit, but rather it is an assemblage of services that qualified for Medi-Cal reimbursement at one earlier point in time. It is restricted, out-of-date and no longer reflects the growing evidence base in SUD treatments, nor does it reflect the best science regarding treatment of co-occurring mental health and substance use disorders. The Medi-Cal benefit in California should cover the services necessary to create an evidence-based SUD specialty continuum of care supported by National Institute of Health research findings. We would be glad to elaborate on this set of evidence.

Recommendations Regarding D/MC Regulatory Reform:

There is an urgent need to review existing state regulations that govern D/MC services. A specific example of outdated and obstructive regulations are those concerning Narcotic Treatment Programs (NTP's). Nationwide, the federal government (Center for Substance Abuse Treatment within SAMHSA, the FDA and the DEA/DOJ) regulates Narcotic Treatment Programs. In California, additional layers of additional state regulations have been added to govern the operations of NTP's. These added regulations are unnecessary, add cost, create inefficiency, interfere with the delivery of evidence-based treatment and actually prevent the delivery of essential medical and psychiatric services. Additional regulations governing other D/MC benefits also currently inhibit the ability to deliver appropriate care based on proper protocols, assessment, and identified treatment needs.

AB 106 requires improvements, efficiencies, cost reductions, and improvements in service outcomes as part of its legislative mandates. Streamlining processes and eliminating duplicative regulations governing the D/MC program are necessary and must be a part of the transition plan's development.

Recommendations Regarding Integration of SUD Services into Broader Health Care

With the transfer of D/MC to DHCS, with the previously enacted realignment of SUD services to counties, the 1115 waiver in early implementation stages, and the fast approaching healthcare reform date of 2014, now is the time to: 1. begin to fully address the integration of SUD services into healthcare including care within and after criminal justice interventions; 2. Develop cost-effective quality initiatives; and. 3. Improve financing for essential SUD services. SUD and MH services should receive the highest level of administrative oversight to integrate behavioral health as a priority focus throughout the health care system. We recommend the adoption of a statewide model of care supporting the Institute of Medicine's recent conclusions that there can be "no health care without MH and SUD care".

Better integrating SUD and related MH services is challenging but necessary for the good of the patients. Integrating both with the rest of healthcare should be a high level and immediate focus of DHCS during the D/MC transition because there is accumulating evidence that untreated SUDs substantially increase medical costs in the near and long term and that effective SUD and MH treatment lowers overall health care costs. The cost offsets and improved patient outcomes of effectively treating individuals with SUD and MH disorders strongly support arguments to prioritize these integrated care efforts. Because SUD services are not part of the state's Bridge to Reform 1115 waiver, it is essential that there are immediate efforts to promote policies, regulations, and legislation to facilitate integrated care that includes both substance use disorder treatments and mental health treatments. We also need to strategize how best to educate all levels of general health service providers about the beneficial impact of integrated care and fund efforts to evaluate, promote and improve integrated care efforts. We must create accountability and performance management initiatives that reflect HIT advances and expectations and that

provide incentives and a report card as integration progresses and improves. This workgroup has many members who have experience in creating such indicators and interpreting them in order to enhance quality and effectiveness.

The Affordable Care Act will move health service providers to work in new and innovative ways both within their particular health delivery system (e.g. primary medical care, mental health, SUD treatment, etc.) and coordinate care outside of their usual focus. In an integrated system, patients will to be able to enter health services through any "door", whether it is primary medical care, mental health or SUD treatment. Further, health service providers will need to become increasingly integrated for the benefit of providing patient-centered care. With a focus on quality based on science and improvement efforts, the lives of individuals suffering medical, mental health and substance use disorders is improved at reduced overall cost to our society and our healthcare system.